

Drug-induced parkinsonism and tardive dyskinesia in nonpsychiatric patients

To the editor: In her excellent review article on neuroleptics (*Can Med Assoc J* 1981; 125: 821-826) Dr. Mary V. Seeman cautions that the long-term use of neuroleptics should be limited to the management of patients who have schizophrenia.

To emphasize the point that drugs that block dopamine receptors should not be used on a long-term basis for nonpsychotic conditions the following experience is reported.

Over the past 3 years in the Parkinson's disease clinic of the Ottawa Civic Hospital I have seen 39 patients with drug-induced parkinsonism. The drugs most frequently implicated were chlorpromazine, trifluoperazine, haloperidol, prochlorperazine and metoclopramide. The patients, whose average age was 70 years, had been taking these drugs for a few weeks to 11 years. None of the patients were psychotic, and the drugs were most commonly prescribed for chronic anxiety and gastrointestinal complaints. Metoclopramide, a nonphenothiazine compound that actively blocks central dopamine receptors, was a frequent culprit,¹ being responsible for 19 cases.

Drug-induced parkinsonism was initially misdiagnosed as classic Parkinson's disease and treated with levodopa in 14 patients. One of the most outstanding examples of this problem was the case of a 58-year-old man treated with trifluoperazine for the irritable bowel syndrome. Parkinsonism developed after 6 months of trifluoperazine therapy. Levodopa therapy was started, and the man continued taking both drugs for the next 7 years. Trifluoperazine therapy was stopped after his initial visit to the clinic. Levodopa was slowly withdrawn over 5 months, and his severe, disabling parkinsonism cleared completely.

Drug-induced parkinsonism is reversible on withdrawal of the offending drug. Complete clearing may take several months, and some patients may require interim treatment with an anticholinergic or levodopa.

Tardive dyskinesia is a potentially irreversible complication of long-term blockade (usually for 6 months or longer) of dopamine receptors.² It developed in 10 of the 39 patients with parkinsonism and was seen in 18 other nonpsychiatric patients after long-term neuroleptic or metoclopramide therapy. Of the 28 patients 13 appear to have permanent orobuccolingual movement disorders.

The long-term use of neuroleptics or metoclopramide exposes patients to the risk of serious, potentially irreversible neurologic side effects. Prescribing these drugs for long periods in the treatment of relatively minor conditions must therefore be avoided.

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References

1. GRIMES JD, HASSAN MN, PRESTON DN: Adverse neurologic effects of metoclopramide. *Can Med Assoc J* 1981; 126: 23-25
2. SIMPSON GM, PI EH, SRAMEK JJ: Adverse effects of antipsychotic agents. *Drugs* 1981; 21: 138-151

[We showed Dr. Grimes's letter to Dr. Seeman, whose reply follows.—Ed.]

To the editor: I am grateful to Dr. Grimes for putting in writing what I have heard so many neurologists say: that the patients they see with drug-induced parkinsonism and tardive dyskinesia are not, for the most part, individuals with psychotic conditions but, rather, people with relatively mild psychologic symptoms treated over many years with low doses of neuroleptics.

The following conditions are commonly wrongly treated for long periods with neuroleptics:

- Chronic anxiety and its various somatic manifestations. Many physicians, reluctant to prescribe long-term anxiolytic therapy because of problems of abuse, opt instead for the more toxic neuroleptics. Intermittent drug treatment and an emphasis on anxiety-reducing behavioural techniques are preferable.

- Chronic agitated depression. It was fashionable for many years to use a combination of antidepressants and neuroleptics in low doses to treat depression. There are now so many effective antidepressants with various properties that neuroleptics are an unnecessary addition.

- Recurrent bipolar mood disorder. Whereas neuroleptics are urgently needed in acute mania, they are not often necessary for long-term prophylaxis. Maintenance therapy with lithium is safer.

- Recurrent anger and violence. If long-term maintenance therapy is required, anticonvulsants are probably safer.

- Paranoia and paranoid personality. Neuroleptics may be needed for acute episodes but not for long-term care.

- Borderline personality. Brief psychotic episodes may occur and can be managed with intermittent use of neuroleptics for short periods.

- Psychotic symptoms. Hallucinations or depersonalization phenomena or delu-

sions in the absence of other signs of schizophrenia may be secondary to anxiety, to obsessiveness, to a dissociative state or to epilepsy. As such, they respond to a variety of interventions and should not automatically be treated with neuroleptics.

The long-term use of neuroleptics should be avoided whenever possible but should not, of course, be withheld in the prophylaxis of recurrent schizophrenia. During remissions in schizophrenia there may be no symptoms and no observable signs, but maintenance therapy with neuroleptics is none the less essential in order to prevent demoralizing and sometimes dangerous recurrences.

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Neonatal herpes simplex

To the editor: I wish to comment on the article "Genital herpes simplex" by Dr. I.S. Tummon and associates (*Can Med Assoc J* 1981; 125: 23-29). It is difficult to estimate the risk and to manage potential cases of neonatal herpes simplex following asymptomatic maternal shedding of the herpes simplex virus (HSV) during late pregnancy. Most physicians would agree that prompt cesarean section is best in women with clinically apparent primary or recurrent genital herpes simplex, though even this procedure may not always be effective in preventing neonatal infection.¹

It appears from several articles that it is possible to detect HSV shedding from women during late pregnancy.^{2,5} However, in their article Tummon and associates appear to advocate the approach of Amstey and colleagues⁶ for determining the presence of HSV excretion from pregnant women. This method involves doing cervical cultures weekly from the 32nd week of gestation if the mother has a history of HSV infection or sexual contact with someone known to have such an infection. In my view this approach would place an undue burden upon diagnostic virology facilities without firm evidence that it is appropriate or effective. A more moderate and more practical approach is that of the American Academy of Pediatrics, which recommends cervical cultures or cytology for HSV at least twice in the last 6 weeks of gestation.² If either procedure gives positive results, then it would be good practice to continue weekly cultures, as many women will stop shedding HSV closer to term.³

Determination by prospective studies of the risk of neonatal herpes simplex following delivery through an infected birth canal when the mother has clini-